
State:	Arkansas	Filing Company:	Western-Southern Life Assurance Company
TOI/Sub-TOI:	L08 Life - Other/L08.000 Life - Other		
Product Name:	2013 WSLAC MIB Filing/rp/jc		
Project Name/Number:	2013 WSLAC MIB Filing/rp/jc/2013 WSLAC MIB Filing/rp/jc		

Filing at a Glance

Company:	Western-Southern Life Assurance Company
Product Name:	2013 WSLAC MIB Filing/rp/jc
State:	Arkansas
TOI:	L08 Life - Other
Sub-TOI:	L08.000 Life - Other
Filing Type:	Form
Date Submitted:	12/18/2012
SERFF Tr Num:	WSST-128815222
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	WSLAC 2106-1301
Implementation	On Approval
Date Requested:	
Author(s):	Ramona Piercefield, Kimberly Wright, Angelea Underwood, Jaclyn Cox
Reviewer(s):	Linda Bird (primary)
Disposition Date:	12/20/2012
Disposition Status:	Approved-Closed
Implementation Date:	
State Filing Description:	

State:	Arkansas	Filing Company:	Western-Southern Life Assurance Company
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General Information

Project Name: 2013 WSLAC MIB Filing/rp/jc	Status of Filing in Domicile: Pending
Project Number: 2013 WSLAC MIB Filing/rp/jc	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments: Ohio is our state of domicile
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 12/20/2012
	State Status Changed: 12/20/2012
Deemer Date:	Created By: Ramona Piercefield
Submitted By: Ramona Piercefield	Corresponding Filing Tracking Number:

Filing Description:

RE: MIB Authorization change Effective January 1, 2013

Western-Southern Life Assurance Company, NAIC # 92622
DO-579-1301, Authorization for Application and Policy Issue
2106-1301, HIPAA Compliant Authorization for Release of Health Information

Dear Reviewer,

This filing is being submitted on behalf of the Western-Southern Life Assurance Company.
Effective January 1, 2013, MIB will require all Members to include language in their MIB Authorization that elicits an applicant's express written consent to report information to MIB.

In order to comply with the request, two special authorization forms will be used. Each form submitted for review and approval contains the suggested language from MIB.

Below are the forms numbers and a brief description.

DO-579-1301, Authorization for Application and Policy Issue. This form, when signed by the appropriate party, gives consent to disclose health information. It is to be completed by the parent or owner of the proposed minor insured's policy and authorizes the release of any information collected to MIB.

2106-1301, HIPAA Compliant Authorization for Release of Health Information. This form, when signed by the Insured, gives consent to disclose health information and authorizes the release of any information collected to MIB.

A Statement of Variability is attached under Supporting Documentation to address variability.

Please also note that the authorization forms are intended to supersede authorizations signed within the application packet beginning January 1, 2013, and later.

These authorizations are intended to be used with all applications being submitted for the Western-Southern Life Assurance Company.

Thank you for your consideration and we look forward to your approval.

State: Arkansas **Filing Company:** Western-Southern Life Assurance Company
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: 2013 WSLAC MIB Filing/rp/jc
Project Name/Number: 2013 WSLAC MIB Filing/rp/jc/2013 WSLAC MIB Filing/rp/jc

Ramona Piercefield
Insurance Compliance Analyst
Western and Southern Financial Group
1-800-446-0795 (1873)

Company and Contact

Filing Contact Information

Ramona Piercefield, Product & State Filing Analyst
Ramona.Piercefield@wslife.com
400 Broadway 800-446-0795 [Phone] 1873 [Ext]
Cincinnati, OH 45202 513-357-4123 [FAX]

Filing Company Information

Western-Southern Life Assurance Company	CoCode: 92622	State of Domicile: Ohio
400 Broadway	Group Code: 836	Company Type: Life
Cincinnati, OH 45202	Group Name: West-Southern Group	State ID Number:
(800) 446-0795 ext. [Phone]	FEIN Number: 31-1000236	

Filing Fees

Fee Required? Yes
Fee Amount: \$100.00
Retaliatory? No
Fee Explanation: \$50.00 per form x 2 forms = \$100.00
Per Company: No

Company	Amount	Date Processed	Transaction #
Western-Southern Life Assurance Company	\$100.00	12/18/2012	65843962

State:	Arkansas	Filing Company:	Western-Southern Life Assurance Company
TOI/Sub-TOI:	L08 Life - Other/L08.000 Life - Other		
Product Name:	2013 WSLAC MIB Filing/rp/jc		
Project Name/Number:	2013 WSLAC MIB Filing/rp/jc/2013 WSLAC MIB Filing/rp/jc		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	12/20/2012	12/20/2012

State:	Arkansas	Filing Company:	Western-Southern Life Assurance Company
TOI/Sub-TOI:	L08 Life - Other/L08.000 Life - Other		
Product Name:	2013 WSLAC MIB Filing/rp/jc		
Project Name/Number:	2013 WSLAC MIB Filing/rp/jc/2013 WSLAC MIB Filing/rp/jc		

Disposition

Disposition Date: 12/20/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Statement of Variability		Yes
Form	HIPAA Compliant Authorization for Release of Health Information		Yes
Form	Authorization for Application and Policy Issue		Yes

SERFF Tracking #:

WSST-128815222

State Tracking #:

Company Tracking #:

WSLAC 2106-1301

State: Arkansas

TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other

Product Name: 2013 WSLAC MIB Filing/rp/jc

Project Name/Number: 2013 WSLAC MIB Filing/rp/jc/2013 WSLAC MIB Filing/rp/jc

Filing Company:

Western-Southern Life Assurance Company

Form Schedule

Lead Form Number: 2106-1301

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		HIPAA Compliant Authorization for Release of Health Information	2106-1301	POLA	Initial		50.000	2106-1301.pdf
2		Authorization for Application and Policy Issue	DO-579-1301	POLA	Initial		50.000	DO-579-1301.pdf

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages

HIPAA Compliant Authorization for Release of Health Information

The Western and Southern Life Insurance Company

Western-Southern Life Assurance Company

400 Broadway Cincinnati, OH 45202

This authorization form is intended to supersede authorizations signed within the application packet beginning January 1, 2013 and later.

I (We), individually (and/or on behalf of any below-named children, individually), hereby consent and authorize any health plan, physician, medical practitioner, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, other medical or medically related facility, or other health care provider that has provided payment, treatment or services to me or on my behalf (hereafter, My Providers) to disclose my entire medical record, prescription history, medications prescribed and any other health information concerning me (protected health information) to The Western and Southern Life Insurance Company or Western-Southern Life Assurance Company (hereafter, "the Company"). I (We) also authorize any insurance company or agent from which I (we) have applied for or obtained insurance, MIB, Inc., consumer reporting agency, my employer, or other company or institution that has provided payment, treatment or services, or any other entity or person information about me, to disclose it to the Company. Protected health information includes information on the diagnosis, prognosis, or treatment relative to any physical, or mental condition, or treatment related to drug or alcohol use, or Acquired Immune Deficiency Syndrome (AIDS), AIDS-related Complex (ARC) and/or tests for antibodies to the AIDS Virus (HIV), but excludes psychotherapy notes.

The signature(s) below acknowledge that any agreements I (we) have made to restrict my protected health information do not apply to this Authorization and I (we) instruct any of My Providers and other entities or persons referred to above to release and disclose my/our health information without restriction.

This protected health information is to be used or disclosed under this Authorization so that the Company may: 1) underwrite applications for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine full responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I (we) have or have applied for with the Company.

I (We) also authorize the Company or its reinsurers to release any information collected about me to MIB, Inc. and to other insurance companies with whom I (we) may apply for insurance.

This authorization shall remain in effect for 24 months following the date of signature(s) below. A copy of the authorization is as valid as the original. I, each Proposed Insured, Named Child or Legal Representative, understand that I (we) have the right to obtain a copy of and revoke this authorization at any time by notifying the Company in writing at 400 Broadway, Cincinnati, Ohio, 45202-3312, Attention: Privacy Officer. I (We) understand that a revocation is not effective to the extent that any person or entity has already relied on this Authorization to disclose or use information about me or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I (We) understand that if any of my protected health information is re-disclosed, it may no longer be protected by federal rules governing privacy and confidentiality of health information. Health Care and payment for health care will not be affected by refusal to sign this authorization. I (We) further understand that if I (we) refuse to sign this Authorization, the Company may not be able to process my application, or if coverage has been issued, may not be able to make any benefit determinations or payments. I (We) understand that I (we) or any authorized representative will receive a copy of this Authorization.

Signature of Proposed Insured or Legal Representative

Date

Signature of Additional Proposed Insured

Date

Witness (Agent, if present)

Date

Full Names of Children Proposed for Insurance



- ☐ THE WESTERN AND SOUTHERN LIFE INSURANCE COMPANY
☐ WESTERN-SOUTHERN LIFE ASSURANCE COMPANY

**AUTHORIZATION FOR APPLICATION
AND POLICY ISSUE**

The Western and Southern Life Insurance Company or Western-Southern Life Assurance Company requires the natural or adoptive parent of a minor to complete this form prior to issuing a contract not owned by a natural or adoptive parent.

Proposed Minor Insured: _____ Date of Birth: _____

Applicant and Owner: _____

I, the undersigned and natural (or adoptive) parent of the minor child listed above, hereby authorize and request The Western and Southern Life Insurance Company or Western-Southern Life Assurance Company to accept an application and to issue a policy insuring the life of the minor child above, as nearly in accordance with the application signed by the Applicant as the practice of The Western and Southern Life Insurance Company or Western-Southern Life Assurance Company will permit.

I further authorize and request the designation of the said Applicant as Owner of this policy of life insurance and acknowledge that the Applicant may designate any Beneficiary and/or Successor Owner of his/her choosing.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

(This Authorization is intended to comply with the HIPAA Privacy Rule)

This authorization form is intended to supersede authorizations signed within the application packet beginning January 1, 2013 and later.

The undersigned, on behalf of any above-named child, hereby consent and authorize any health plan, physician, medical practitioner, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, other medical or medically related facility, or other health care provider that has provided payment, treatment or services to the named child or on their behalf (hereafter, Providers) to disclose the named child's entire medical record, prescription history, medications prescribed and any other health information concerning them (protected health information) to The Western and Southern Life Insurance Company or Western-Southern Life Assurance Company (hereafter, "the Company"). I also authorize any insurance company or agent from which insurance has been applied for or obtained, MIB, Inc., consumer reporting agency, my employer, or other company or institution that has provided payment, treatment or services, or any other entity or person information about the named child, to disclose it to the Company. Protected health information includes information on the diagnosis, prognosis, or treatment relative to any physical, or mental condition, or treatment related to drug or alcohol use, or Acquired Immune Deficiency Syndrome (AIDS), AIDS-related Complex (ARC) and/or tests for antibodies to the AIDS Virus (HIV), but excludes psychotherapy notes.

The signature below acknowledges that any agreements I have made to restrict the named child's protected health information do not apply to this Authorization and I instruct any of Providers and other entities or persons referred to above to release and disclose their health information without restriction.

This protected health information is to be used or disclosed under this Authorization so that the Company may: 1) underwrite applications for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine full responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage applied for with the Company.

I also authorize the Company or its reinsurers to release any information collected about the named child to MIB, Inc. and to other insurance companies with whom they may apply for insurance.

This authorization shall remain in effect for 24 months following the date of signature below. A copy of the authorization is as valid as the original. I the legal representative or the named child, understand that I have the right to obtain a copy of and revoke this authorization at any time by notifying the Company in writing at 400 Broadway, Cincinnati, Ohio, 45202-3312. Attention: Privacy Officer. I understand that a revocation is not effective to the extent that any person or entity has already relied on this Authorization to disclose or use information about me or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that if any of my protected health information is re-disclosed, it may no longer be protected by federal rules governing privacy and confidentiality of health information. Health Care and payment for health care will not be affected by refusal to sign this authorization. I further understand that if I refuse to sign this Authorization, the Company may not be able to process my application, or if coverage has been issued, may not be able to make any benefit determinations or payments. Understand that I or any authorized representative will receive a copy of this Authorization.

Printed name of person whose signature appears below

Signature of ☐ Father or ☐ Mother of the Proposed Insured or ☐ Legal Guardian

Date

Return completed form to: **Western & Southern Financial Group**

New Business Department
400 Broadway
Cincinnati, OH 45202-3312

State:	Arkansas	Filing Company:	Western-Southern Life Assurance Company
TOI/Sub-TOI:	L08 Life - Other/L08.000 Life - Other		
Product Name:	2013 WSLAC MIB Filing/rp/jc		
Project Name/Number:	2013 WSLAC MIB Filing/rp/jc/2013 WSLAC MIB Filing/rp/jc		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
WSLAC Flesch Certification.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Statement of Variability		
Comments:			
Attachment(s):			
MIB WSLAC Auth. Forms SOV.pdf			

Western-Southern Life Assurance Company

NAIC CODE # 92622

CERTIFICATION

I, Michael Moser, an officer of Western-Southern Life Assurance Company hereby certify that the following forms have the following readability scores as calculated by the Flesch Reading Ease Test and that these forms meet the reading ease requirements of your state Statutes and Regulations.

Form Numbers	Readability Score
2106-1301, HIPAA Compliant Authorization for Release of Health Information *	50
DO-579-1301 Authorization For Application And Policy Issue *	50

*Flesched with 0807-4000 WSA, Flexible Premium Adjustable Life Insurance Policy



Michael Moser
Vice President & Chief Compliance Officer

Date: 12/17/2012

Statement of Variability

December 17, 2012

This Statement of Variability applies to the following forms:

Western and Southern Life Assurance Company

DO-579-1301, The Authorization for Application and Policy Issue

2106-1301, HIPAA Compliant Authorization for Release of Health Information

The variable information is identified by brackets and may change as indicated below.

COMPANY LOGO: The flexibility to change our logo does not include the Company name. We understand if our Company name changes for any reason we must notify the Department accordingly.

ADMINISTRATIVE OFFICE: We may change our administrative address, telephone number, department name and web site if such items should change in the future. We may remove any reference to the Company web site unless it is required to appear by state law,